

		FOR OHF USE					

LL 1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0035881</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Mother Theresa Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/99</u> to <u>06/30/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1270 Franciscan Drive</u> <u>Lemont</u> <u>60439</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Richard Truesdale</u> (Title) <u>Treasurer</u>	
Telephone Number: <u>630-257-5801</u> Fax # <u>630-257-3987</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>36-2548288001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>04/19/65</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Richard Truesdale</u> Telephone Number: <u>630-257-3994, Ext. 311</u>			

Facility Name & ID Number Mother Theresa Home# 0035881 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>28</u>	Intermediate (ICF)	<u>28</u>	<u>10,248</u>	3
4		Intermediate/DD			4
5	<u>2</u>	Sheltered Care (SC)	<u>2</u>	<u>732</u>	5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,900</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>381</u>	<u>1,766</u>		<u>2,147</u>	8
9	SNF/PED					9
10	ICF	<u>17,596</u>	<u>29,514</u>		<u>47,110</u>	10
11	ICF/DD					11
12	SC		<u>2,071</u>		<u>2,071</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,977</u>	<u>33,351</u>		<u>51,328</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.49%

D. How many bed-hold days during this year were paid by Public Aid?

277 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Beauty Shop and meals for Franciscan Village residentsF. Does the facility maintain a daily midnight census? yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 01/23/90

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: June 30 Fiscal Year: June 30

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Mother Theresa Home

0035881

Report Period Beginning:

07/01/99

Ending:

06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	722,094	113,430	12,678	848,202		848,202		848,202			1
2	Food Purchase		580,892		580,892		580,892	(580,158)	734			2
3	Housekeeping	222,034	36,112	2,138	260,284		260,284		260,284			3
4	Laundry			125,547	125,547		125,547		125,547			4
5	Heat and Other Utilities			162,542	162,542		162,542		162,542			5
6	Maintenance	102,687	47,885	50,883	201,455	5,431	206,886		206,886			6
7	Other (specify):* trash removal			25,028	25,028		25,028		25,028			7
8	TOTAL General Services	1,046,815	778,319	378,816	2,203,950	5,431	2,209,381	(580,158)	1,629,223			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,328,199	509,084	505,144	3,342,427	(367,421)	2,975,006		2,975,006			10
10a	Therapy	92,817	6,225	12,869	111,911		111,911		111,911			10a
11	Activities	125,507	9,692	5,996	141,195		141,195		141,195			11
12	Social Services	82,224	1,066		83,290		83,290		83,290			12
13	Nurse Aide Training											13
14	Program Transportation			3,846	3,846		3,846		3,846			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,628,747	526,067	527,855	3,682,669	(367,421)	3,315,248		3,315,248			16
	C. General Administration											
17	Administrative	86,600		47,297	133,897		133,897		133,897			17
18	Directors Fees											18
19	Professional Services			323,179	323,179		323,179	(87,151)	236,028			19
20	Dues, Fees, Subscriptions & Promotions			42,391	42,391	49	42,440	(3,067)	39,373			20
21	Clerical & General Office Expenses	52,667	14,192	28,368	95,227	(49)	95,178		95,178			21
22	Employee Benefits & Payroll Taxes			681,558	681,558		681,558		681,558			22
23	Inservice Training & Education			7,168	7,168		7,168		7,168			23
24	Travel and Seminar			9,204	9,204		9,204	(3,054)	6,150			24
25	Other Admin. Staff Transportation			427	427		427		427			25
26	Insurance-Prop.Liab.Malpractice			69,151	69,151		69,151		69,151			26
27	Other (specify):*											27
28	TOTAL General Administration	139,267	14,192	1,208,743	1,362,202		1,362,202	(93,272)	1,268,930			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,814,829	1,318,578	2,115,414	7,248,821	(361,990)	6,886,831	(673,430)	6,213,401			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Mother Theresa Home

#0035881

Report Period Beginning:

07/01/99

Ending:

06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			341,252	341,252	(9,585)	331,667		331,667			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			364,811	364,811		364,811	(53,727)	311,084			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			15,337	15,337		15,337		15,337			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			721,400	721,400	(9,585)	711,815	(53,727)	658,088			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					367,421	367,421		367,421			39
40	Barber and Beauty Shops	90,532	5,130		95,662	4,154	99,816	(69,674)	30,142			40
41	Coffee and Gift Shops	6,040	16,308		22,348		22,348		22,348			41
42	Provider Participation Fee			81,252	81,252		81,252		81,252			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	96,572	21,438	81,252	199,262	371,575	570,837	(69,674)	501,163			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,911,401	1,340,016	2,918,066	8,169,483		8,169,483	(796,831)	7,372,652			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Mother Theresa Home

0035881

Report Period Beginning: 07/01/99

Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(580,158)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(53,727)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,018)	20		18
19	Entertainment	(1,431)	24		19
20	Contributions	(1,623)	24		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(87,151)	19		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(49)	20		28
29	Other-Attach Schedule beauty shop	(69,674)	40		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (796,831)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (796,831)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs	x		367,421	10	43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 367,421		47

Mother Theresa Home

ID# 0035881

Report Period Beginning: 07/01/99

Ending: 06/30/00

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	beauty revenue, non residents	\$	(69,674)	48
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
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47				47
48				48
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66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(69,674)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mother Theresa Home

0035881

Report Period Beginning:

07/01/99

Ending:

06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(580,158)	0	0	0	0	0	0	0	0	0	0	(580,158)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(580,158)	0	0	0	0	0	0	0	0	0	0	(580,158)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(87,151)	0	0	0	0	0	0	0	0	0	0	(87,151)	19
20	Fees, Subscriptions & Promotions	(3,067)	0	0	0	0	0	0	0	0	0	0	(3,067)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,054)	0	0	0	0	0	0	0	0	0	0	(3,054)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(93,272)	0	0	0	0	0	0	0	0	0	0	(93,272)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(673,430)	0	0	0	0	0	0	0	0	0	0	(673,430)	29

Summary B

06/30/00

06/30/00

[illegible]

Facility Name & ID Number Mother Theresa Home

0035881

Report Period Beginning:

07/01/99

Ending:

06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mother Theresa Home	100	St. Joseph Home of Chicago	Chicago, IL	Franciscan Village	Lemont, IL	Retirement Comm
		Franciscan Homes & Community Services	Crown Point, IN	Franciscan Sisters of C	Lemont, IL	Religious Congreg
		Mt. Alverna Home	Parma, OH	Franciscan Sisters of Chicago Service Corp.		Corporate Service
see PG 6 ADD for additional related parties		Addolorata Villa	Wheeling, IL		Homewood, IL	Religious Congreg
		George Davis Manor	Lafayette, IN	Franciscan Communities Home Care		
		St. Elizabeth's Healthcare Center	Delphi, IN		Lemont, IL	Home Health Care
		St. Clare Healthcare Center	Otterbein, IN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	19	Financial, Human Resource,	\$ 306,450	Franciscan Village	0.00%	\$ 306,450	\$	1
2	V		Marketing, Development,						2
3	V		Mission Integration &						3
4	V		Volunteer Services						4
5	V	34	Land Lease	15,337	Franciscan Sisters of Chicago	0.00%	15,337		5
6	V	14	Recreation travel expenses (Bus)	3,846	Franciscan Village	0.00%	3,846		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 325,633			\$ 325,633	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Mother Theresa Home # 0035881 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	FSCSC for Sr. Lora Ann Slaw	Regional VP		0.00		13	33.00	Salary	\$ 47,297	17/3	1
2	FSC for Sr. Jean Therese	Ward Clerk		0.00		40	100.00	Salary	18,800	10/1	2
3	FSC for PastoralCare Service	Pastoral Care		0.00		27	67.00	Salary	14,223	10/1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 80,320		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mother Theresa Home# 0035881

Report Period Beginning:

07/01/99Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Franciscan Sisters of ChicagoStreet Address 14700 Main StreetCity / State / Zip Code Lemont, IL 60439Phone Number (630-257-7776Fax Number (630-257-7887

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry Services	per pound	1		\$ 125,547	\$	1	\$ 125,547	1
2	5	Water/Sewer	per gallon	1		16,299		1	16,299	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 141,846	\$		\$ 141,846	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Franciscan Village	x		New Construction	\$37,697.00	07/01/90	\$ 5,135,000	\$ 4,512,261	07/01/21	8.0000	\$ 364,811	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$37,697.00		\$ 5,135,000	\$ 4,512,261			\$ 364,811	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,135,000	\$ 4,512,261			\$ 364,811	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Mother Theresa Home**# **0035881** Report Period Beginning: **07/01/99** Ending: **06/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	0	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

A. Square Feet:

68,293

B. General Construction Type:

Exterior

Brick/Masonry

Frame

Steel

Number of Stories

3

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Franciscan Village, Inc.

a retirement community, consisting of: 50 Independent Living Coach Homes, 48,000 square feet

150 Independent Living Apartments, 143,094 square feet

30 Assisted Living Apartments, 20,334 square feet

Our Lady of Victory Convent - Motherhouse of the Franciscan Sisters of Chicago

Franciscan Communities Home Care located inside Our Lady of Victory Convent

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Note: Mother Theresa Home does		1989	\$ 293,706	1
2	not own the land - It is leased from FSC				2
3	TOTALS			\$ 293,706	3

Facility Name & ID Number Mother Theresa Home

0035881

Report Period Beginning:

07/01/99

Ending:

06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1990	1989	\$ 5,724,856	\$ 202,437	30	\$ 202,437		\$ 2,110,010	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements, roads, trees, etc			1990	262,081	9,066	20	9,066		94,387	9
10											10
11	Wall guards			1992	5,771	364	15	364		3,057	11
12	Dishwashing Rooms/Nurses Station			1993	129,233	15,562	10	15,562		104,466	12
13	Landscaping - shrubbery			1993	6,581	329	20	329		2,248	13
14	Dining Room/Activity Room expansions			1993	652,933	21,764	30	21,764		143,282	14
15	Wall covering - dining room			1994	522		5			522	15
16	Donor wall by chapel			1994	13,016	434	30	434		2,676	16
17	Patio fencing			1994	1,805	219	8	219		1,496	17
18	Kitchen tiles/shelving			1993	4,159	209	20	209		1,155	18
19											19
20	Kitchen remodeling			1995	116,616	4,248	various	4,248		21,141	20
21	Landscaping - shrubbery			1995	620	62	10	62		300	21
22	Parking lot extension			1995	16,400	820	20	820		3,963	22
23	Computer networking			1995	15,097	3,019	5	3,019		13,838	23
24	1st Floor Nurses Station remodeling			1995	12,016	2,403	5	2,403		11,545	24
25	Signage (name plates, etc. throughout building)			1996	799	40	20	40		167	25
26	carpet-administrators office			1996	565	113	5	113		462	26
27	shades - 2nd floor dining room			1996	1,528	306	5	306		1,224	27
28	outdoor handrailing			1996	535	107	5	107		473	28
29	chapel ventilation			1996	27,393	2,739	10	2,739		11,185	29
30	wall coverings - 2nd & 3rd floor dining rooms			1997	4,242	848	5	848		3,181	30
31	Electric door closers			1997	1,101	110	10	110		367	31
32	Dish room renovation			1997	15,850	1,585	10	1,585		4,755	32
33	Parking lot paving			1998	7,000	875	8	875		2,333	33
34	Food Service Hallway Renovation			1998	4,654	665	7	665		1,330	34
35	Replacement doors			1998	1,920	118	15	118		260	35
36	TOTAL (lines 4 thru 35)				\$ 7,027,293	\$ 268,442		\$ 268,442		\$ 2,539,823	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mother Theresa Home

0035881

Report Period Beginning:

07/01/99

Ending:

06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Doors/Exit Devices			1999	3,127	191	15	191		260	9
10	Carpet- Administration area - 2nd floor			1999	2,515	461	5	461		629	10
11	Fire Alarm Door Upgrades - required			1999	18,952	1,158	15	1,158		1,474	11
12	Replacement Doors			2000	1,745	97	15	97		97	12
13	Floor tile & installation			2000	5,675	261	20	261		261	13
14	Keypad locks for doors			2000	3,361	446	5	446		446	14
15	Clinic Sink - wall mount			2000	763	51	10	51		51	15
16	Roof top Air conditioner			2000	10,418	116	15	116		116	16
17	Elevator flooring			2000	1,909		3				17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 48,465	\$ 2,781		\$ 2,781	\$	\$ 3,334	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 752,487	\$ 41,618	\$ 41,618	\$	various	\$ 423,659	37
38	Current Year Purchases	83,494	5,462	5,462		10	5,462	38
39	Fully Depreciated Assets	88,031	10,229	10,229		various	88,031	39
40								40
41	TOTALS	\$ 924,012	\$ 57,309	\$ 57,309	\$		\$ 517,152	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Administration/Activities	1996 Chevrolet Lumina	1996	\$ 15,050	\$ 3,135	\$ 3,135	\$		\$ 15,050	42
43										43
44										44
45										45
46	TOTALS			\$ 15,050	\$ 3,135	\$ 3,135	\$		\$ 15,050	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 8,308,526	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 331,667	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 331,667	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 3,075,359	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Beauty Shop/Pastoral Care offices	\$ 115,982	\$ 3,866	\$ 32,218	52
53	Beauty Shop Equipment	2,338	117	1,181	53
54	Chevy Truck 1997	21,723	5,431	18,103	54
55	Adjustable Shampoo sink	2,569	171	171	55
56					56
57	TOTALS	\$ 142,612	\$ 9,585	\$ 51,673	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$

13. /2002 \$

14. /2003 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39	# of prescrpts				367,421		367,421		9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$ 367,421		\$ 367,421		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Mother Theresa Home

0035881

Report Period Beginning: 07/01/99

Ending:

06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 102,838	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	1,720,476		3
4	Supply Inventory (priced at cost)	58,077		4
5	Short-Term Investments	478,739		5
6	Prepaid Insurance	52,958		6
7	Other Prepaid Expenses	38,681		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,451,769	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	292,682		13
14	Buildings, at Historical Cost	7,157,681		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,000,775		16
17	Accumulated Depreciation (book methods)	(3,127,032)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,324,106	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,775,875	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,068,653	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	220,000		28
29	Short-Term Notes Payable	94,583		29
30	Accrued Salaries Payable	245,687		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,628,923	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,417,678		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,417,678	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,046,601	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,729,274	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,775,875	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,070,006	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,070,006	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(347,168)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) net change in unrealized gains on inv.	10,356	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (336,812)	17
	B. Transfers (Itemize):		
18	contr for specific programs	(3,920)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3,920)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,729,274	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mother Theresa Home

0035881

Report Period Beginning: 07/01/99

Ending:

06/30/00

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,059,019	1
2	Discounts and Allowances for all Levels	(1,113,121)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,945,898	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	369	11
12	Gift and Coffee Shop	44,278	12
13	Barber and Beauty Care	107,110	13
14	Non-Patient Meals	580,158	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 731,915	23
D. Non-Operating Revenue			
24	Contributions	90,775	24
25	Interest and Other Investment Income***	53,727	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 144,502	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,822,315	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,203,950	31
32	Health Care	3,682,669	32
33	General Administration	1,362,202	33
B. Capital Expense			
34	Ownership	721,400	34
C. Ancillary Expense			
35	Special Cost Centers	118,010	35
36	Provider Participation Fee	81,252	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,169,483	40
41	Income before Income Taxes (line 30 minus line 40)**	(347,168)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (347,168)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Mother Theresa Home**# **0035881**Report Period Beginning: **07/01/99**

Ending:

06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,536	1,720	\$ 48,774	\$ 28.36	1
2	Assistant Director of Nursing	3,933	4,395	89,146	20.28	2
3	Registered Nurses	16,616	18,343	390,339	21.28	3
4	Licensed Practical Nurses	12,901	13,587	245,517	18.07	4
5	Nurse Aides & Orderlies	98,600	104,427	1,220,493	11.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,579	8,504	92,817	10.91	8
9	Activity Director	1,415	1,660	29,349	17.68	9
10	Activity Assistants	11,061	11,728	96,158	8.20	10
11	Social Service Workers	6,787	7,298	82,224	11.27	11
12	Dietician	1,832	2,004	50,340	25.12	12
13	Food Service Supervisor	10,558	11,389	150,763	13.24	13
14	Head Cook	9,871	10,823	105,157	9.72	14
15	Cook Helpers/Assistants	57,057	60,082	421,874	7.02	15
16	Dishwashers					16
17	Maintenance Workers	6,406	6,406	102,687	16.03	17
18	Housekeepers	25,396	27,848	222,034	7.97	18
19	Laundry					19
20	Administrator	904	1,040	36,613	35.20	20
21	Assistant Administrator	1,672	1,816	49,987	27.53	21
22	Other Administrative	1	1		0.00	22
23	Office Manager	1,909	2,120	33,400	15.75	23
24	Clerical	10,092	10,642	88,797	8.34	24
25	Vocational Instruction	2,026	2,243	43,882	19.56	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,527	6,241	123,946	19.86	31
32	Other Health Care(specify)					32
33	Other(specify) <u>beauty/barber</u>			90,532		33
34	TOTAL (lines 1 - 33)	293,679	314,317	\$ 3,814,829 *	\$ 12.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant	41	1,833	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,700	10/3	39
40	Physical Therapy Consultant	179	9,396	10a/3	40
41	Occupational Therapy Consultant	69	3,473	10a/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	385	\$ 17,402		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	108	\$ 4,603	10/3	50
51	Licensed Practical Nurses	2,055	67,853	10/3	51
52	Nurse Aides	23,219	428,155	10/3	52
53	TOTAL (lines 50 - 52)	25,382	\$ 500,611		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
Theresa Kolaz	Pres/CEO	0	\$ 36,613	Workers' Compensation Insurance	\$	95,969	IDPH License Fee	\$	0		
Jan Nass	Asst. Adm.	0	49,987	Unemployment Compensation Insurance		10,273	Advertising: Employee Recruitment		32,317		
				FICA Taxes		290,351	Health Care Worker Background Check				
				Employee Health Insurance		179,796	(Indicate # of checks performed <u>56</u>)		396		
				Employee Meals		0	Life Services Network		5,381		
				Illinois Municipal Retirement Fund (IMRF)*		0	Various Memberships & Periodicals		1,279		
				401 K contributions		76,794	Yellow page advertising		49		
				Employee Physicals and Holiday gifts		26,794					
				Life Insurance		1,581					
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$	86,600						
B. Administrative - Other											
Description				Amount							
FSCSC for				\$			Less: Public Relations Expense	(
Sr. Lora Ann- Reg VP				47,297			Non-allowable advertising	(
							Yellow page advertising		(49)		
TOTAL (agree to Schedule V, line 17, col. 3)				\$	47,297	TOTAL (agree to Schedule V,		TOTAL (agree to Sch. V,	\$		
(Attach a copy of any management service agreement)						line 22, col.8)	\$	681,558	line 20, col. 8)	39,373	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid				G. Schedule of Travel and Seminar**			
Vendor/Payee				Description				Description			
Type				Line #				Amount			
Amount				Amount				Amount			
Franciscan Village	Financial Services	\$	146,156			\$		Out-of-State Travel	\$	0	
Franciscan Village	Human Resources Services		45,714								
Franciscan Village	Development Services		48,569								
Franciscan Village	Marketing Services		38,582					In-State Travel			
Franciscan Village	Mission Integration Services		16,473					mileage, meal costs, etc.		2,294	
Franciscan Village	Volunterr Coordination Services		10,956					travel/entertainment		1,431	
Ernst & Young, LLP	Audit Services		15,239					gifts/charity		1,623	
Hall, Render, Killian, Heath & Lyman	Legal Services		1,490					Seminar Expense			
								see schedule		3,856	
	</										

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number Mother Theresa Home

STATE OF ILLINOIS

0035881

Report Period Beginning: 07/01/99

Ending: 06/30/00

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Life Services Network \$5,381
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,965 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 81,252
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? n/a Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 90%
d. Have vehicle usage logs been maintained? no
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Ernst & Young, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Have not received final audit
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

Mother Theresa Home
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07/01/99-06/30/00

Detail for Schedule V, line 23 \$7,168

Rush Alzheimer's Disease Center
Staff Education & Dementia Care
for Nursing Home Staff \$5,860

Terra Nova Films
In-Service Film
Choice & Challenge \$160

GIA Publ..
MI - Choral Reading Packet \$18

LTC Assoc
Resource Manuals: Psychotropic/
Restraint Reduction/Rehab/Rest \$135

Sysco
Food Service Sanitation Course for
Alexandrea Kociolek, Cook
Haline Wyrot, Cook
Anna Krzemian, Food Serv. Asst \$600

Center for Eldercare Choices
Jan Nass, Asst. Adm.
Gerontology Course 12/99 \$395

\$7,168

Mother Theres Home
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07/01/99-06/30/00

Schedule V, line 24 detail

LSN Conference	April, 2000 Approx 20 staff members attended the various conferences offered in their fields	\$2,420
INHAA	Franna Marzalek, DON 2/10/00	\$85
Lincoln Land Comm. Coll	Barb Pirc, Staff Dev. Bonnie Wilson, RN C.N.A. Instruction Conference 4/00	\$110
Fred Boch, BCD	Linda Kay, Soc. Serv Dir Kerrie Stafford, Soc. Serv Coor Soc. Service Workshop 1/25/00	\$150
Pastoral Ministry Inst	Fr. Noel Wall, Ministry of Care Institute Oct-99	\$40
Carondolet Management Inst	Fr. Noel Wall, Br. Mark Zapczynski Care for Spiritual needs of sick, dying & bereavement 12/99	\$190
Rush Alz	Barb Pirc, Staff Dev., Celebrate the C.N.A. 10/99	\$75
Rush Alz	Bonnie Wilson, RN - Dementia Mapping 10/99	\$350
College of Dupage	M. Clifton, RN, HSM, J. Solomon, LPN, HSM, Carmen Rosaria, RN, PM Sup Nursing Conference 3/00	\$226
SIU School of Med	Connie Jarosz, Act. Dir & J. Solomon, LPN, HSM Conference 5/00	\$70
SIU School of Med	Ann Schubert, Dietitian, Prof. workshop 1/00	\$35
Sub. Area on Aging	Terry Kolaz, Adm.; Jan Nass, Asst. Adm.; Franna Marszalek, DON - presenters at conference 4/00	\$105
mileage reimbursements, meal costs, etc.		\$2,294
		\$6,150

Mother Theresa Home
0035881
07/01/99-06/30/00

Board of Directors

Chairperson

Sr. M. Helene Galuszka
General Treasurer of Franciscan

Theresa Kolaz
President of Mother Theresa Home

Rev. Kevin Spiess
Pastor of St. Alphonsus Parish in Lemont - no business transactions with Mother Theresa Home

Stephen Bedell
Employed by Gardner, Carten & Douglas - no business transactions with Mother Theresa Home

Connie Markiewicz
Employed by Argonne National Laboratory - no business transactions with Mother Theresa Home

Facility Name & ID Number Mother Theresa Home# 0035881

Report Period Beginning:

07/01/99

Ending:

06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Franciscan Health Care Center	Louisville, KY	Franciscan Home Care	Crown Point, IN	Retirement Comm
		St. Mary Healthcare Center	Lafayette, IN	St. Anthony Hospice	Crown Point, IN	Religious Congregation
		St. James Manor & Villas	Crete, IL	Madonna High School	Chicago, IL	Corporate Service of
				Marian Village	Lockport, IL	Religious Congregation
				St. Jude House	Crown Point, IN	
						Home Health Care

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ ±	14

Mother Theresa Home

0035881

7/1/99-6/30/00

Details of Schedule V - Column 5

line 6	\$5,431 depreciation, non-care asset, reclassified from line 30
line 10	-\$367,421 pharmacy, reclassified to line 39
line 20	\$49 yellow page ad, from line line 21
line 21	-\$49 yellow page ad, to line 20
line 30	-\$9,585 depreciation, non-care asset, to line 6 and line 40
line 39	\$367,421 pharmacy, from line 10
line 40	<u>\$4,154 depreciation, non-care asset, from line 30</u>
	\$0

Details of S